Topic 20: *Interdisciplinary Collaboration for Elder Care*

Competencies

1. Define collaboration and the need for an interdisciplinary approach to geriatric care.
2. Describe types of teams and stages of team development.
3. Differentiate the education and skills among the different professionals on geriatric health-care teams; the overlapping skills of physicians, nurses, and social workers; and individual/team activities.
4. Define the principles of effective teamwork and steps in the care-planning process.
5. Discuss the concept of team conflict and conflict management skills.

Topic 20: *Interdisciplinary Collaboration for Elder Care*

Content Outline

1. Define collaboration and the need for an interdisciplinary approach to geriatric care.

A. Collaboration implies a process of shared planning, decision making, responsibility, and accountability in the care of the patient. In collaborative practice, providers work well together through effective communication, trust, mutual respect, and understanding of each other's skills. While some skills and services appear to overlap, most skills and services are complementary and reinforce each other. Collaborative practice and care is cost-efficient.

B. Reasons for collaborative care for older adults:
- Older adults confront chronic and acute medical and psychosocial problems that may be too complex for one provider to handle alone.
- Assembling a group of providers can assure that all issues will be addressed to develop a comprehensive and integrated care plan.
- Working together, providers can increase the coordination and continuity of care.
- Care can be more efficiently delivered.

C. With advanced technology and the growth of community-based care, skilled care that was previously delivered exclusively in the hospital setting is now provided in the person's residence or in a nursing home. Monitoring older adults in these settings requires well-honed

communication skills because providers need to be informed about, understand, and correctly implement complex plans of care. It is crucial to recognize when to alert other providers of a change in the person's status. Team members need to learn what information other team members require to make decisions about treatment.

D. With the advent of managed care there is an emphasis on efficiency and appropriate use of resources. Skills in coordinating care and being responsive to the changing needs of elderly patients are increasingly important. Physicians, nurses, and other providers must recognize when referrals to other providers are necessary and must know what outcomes can be expected. Knowledge of other health providers' skills is critical in the care of frail elders.

2. Describe types of teams and stages of team development.

A. Traditionally, the physician-directed patient and assumed the role as team leader. The physician was the initial contact and often worked independently to address patient's needs. Tests or services are ordered as needed and there was limited input from others. Teams, in contrast, focus on common goals from the unique perspective of what a discipline or expertise can bring to goal achievement in concert with the skills of other team members. Successful or problematic teams can be distinguished by the decision-making processes used to achieve goals through prioritized and agreed upon assignments.

Topic 20: *Interdisciplinary Collaboration for Elder Care*

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B. Types of Teams:

Unidisciplinary teams: A group of different people from the same discipline who work together.

Multidisciplinary teams: A group of people from different disciplines who develop treatment plans independently. Generally, each discipline conducts an independent assessment of the patient.

One person, usually the physician, orders the services and coordinates the care. The group may meet but generally each discipline implements their independent plan as an additional layer of services. There is no joint planning or discussion of how one service effects another. Services may overlap, duplicate and be fragmented.

Interdisciplinary: A group of people from different disciplines who assess and plan care in a collaborative manner. A common goal or goals is established and each discipline works to achieve that goal.

Care is interdependent, complimentary, and coordinated. Joint decision making is the norm. Members feel empowered and assume leadership on the appropriate issue depending on the patient's needs and the members' expertise.

C. Membership in a team does not automatically mean the group functions well and efficiently. Teams are dynamic entities that evolve and change over time. Effective

teamwork requires specific skills related to group dynamics and conflict management. Members must recognize their role, group responsibility and how they personally effect the team dynamics. Skill development in various team "roles" is critical for well-functioning teams.

D. Most experts believe teams proceed through the following stages of development:*

Forming	Creation stage for the group.
Storming	Tasks and roles are worked out through conflict.
Norming	Norms and patterns are worked out.
Confronting	Conflictual stage (some professionals use this label or the storming label, but not both).
Performing	Team working together for the care of the patient.

3. Differentiate the education and skills among different professionals on geriatric health-care teams; the overlapping skills of physicians, nurses, and social workers; and individual/team activities.

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*Tuckman, B. W. Developmental Sequence in Small Groups. *Psychological Bulletin,* 1965, *63*(6), 384–399. Cited by: Long, D. M., Wilson, N. L., Drinka, T., Woods, A. M., and Gill, M. S. (Eds.), *Houston Geriatric Interdisciplinary Team Training Manual.* Houston, TX: Huffington Center on Aging; 1998.

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A. Team members from different disciplines bring unique sets of skills but some skills may overlap, for example, interviewing skills. Understanding the skills and education of various team members contributes to respect and appropriate referral of elderly clients to other professionals. Each profession has its own culture and trains its members in a common language, professional behaviors, values, and beliefs. Sometimes there is disagreement because expectations of and language between professional groups create confusion. Most professional training is done in a vacuum. Professionals learn what other professionals do only after they are out and practicing.

   Table 20.1 (pages 20-7 and 20-8) describes the practice roles/skills, education, and licensure/credentials of members of an interdisciplinary team.

B. The older client and family are members of the team with full rights to information and participation in decision making.

C. A team focus identifies the older person's needs and problems from the following perspectives:
   - Medical issues and interventions
   - Psychological/emotional issues and interventions
   - Social issues and interventions
   - Economic issues and interventions
   - Living conditions and interventions

Table 20.1 Team Members Overview

Discipline	Practice Roles/Skills	Education/Training	Licensure/Credentials
Nurse (RN, LPN)	Licensed technical (vocational, practical) nurse [LVN, LPN] provides basic nursing care and client teaching under direction and supervision by an RN; may pass meds; often is charge nurse on swing shifts. Registered professional nurse [RN]: assessment, planning, evaluation, coordination of care, teaching, direct and indirect client care.	LVP/LPN: 1–2 years of training; no CEU requirement at present. RN: Associate degree (AD): 2 yrs community college education; Baccalaureate degree (BSN): 4 years college; Masters prepared: 2 years of post-grad study; PhD or EdD: 3–4 years post-grad study that includes research.	LVN/LPN; RN: state licensure exam required for practice; license must be periodically renewed. CEU requirement varies by state.
Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS)	Health assessment, promotion; history and physical exam; risk assessment; order, conduct and interpret some lab and diagnostic tests; prescription privileges (most states); teaching and counseling. Diverse practice specialties. See PA, below.	Masters prepared; state and/or national certification. Education includes advanced physical assessment, pharmacology, client teaching.	Licensed as RN with certificate or licensure in area of specialization; varies by state. CEU requirement and specific hours of practice per year needed to maintain national certification.
Physician (MD)	Diagnose and treat diseases and injuries; preventive care; surgery	Medical school (4 yrs); 3–7 years graduate medical education in area of specialization	State licensure; periodic renewal. Specialty areas may require exam and periodic recertification. CEU requirement varies by state.
Geriatrician	Physician with specialty training in diagnosis, treatment and prevention of disorders in older people.	1–3 year post-grad fellowship[in geriatric medicine.	Certificate of Added Qualification (CAQ) in geriatrics might be required. Geriatric Boards every 10 years
Physician Assistant (PA)[PAC: certified]	Provide a broad range of diagnostic and therapeutic services under supervision of physician; autonomy in medical decision making and practice skills somewhat similar to NP.	2 year PA program in a medical college or university. Most PAs have baccalaureate degrees; many have prior healthcare experience.	Certifying exam (NCCPA) given annually; must be recertified every 6 years via national exam. CEUs: 100 hours very 2 years
Social Worker (MSW)	Assessment of individual and family psychosocial functioning; interventions to enhance or restore autonomous functioning that can include locating community-based support services, individual, family or group counseling. Financial assistance (eg, Medicaid application) and Case Manager role.	BSW: 4 year college degree MSW: 2 years post-graduate education PhD: SWA: social work associate; an individual who has some education and experience but does not meet the full ed or licensure requirement	State certification required for clinical SWs: ACP: licensure for independent clinical practice; LMSW: masters level; LSW: baccalaureate level. CEUs: 15 hours annually, to maintain certification

(continued)

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Table 20.1 *(Continued)*

Discipline	Practice Roles/Skills	Education/Training	Licensure/Credentials
Psychologist	Assessment, treatment and management of emotional and behavioral disorders; psychotherapy with individual, family, groups. No prescription privileges; might use non-pharmacological alternative therapies.	5 years post-grad training that includes clinical experience and coursework in area of specialization	PhD, EdD or PsyD. State licensure required. CEUs:
Psychiatrist	Licensed physician; treats mental, emotional and behavioral diseases and disorders.	2-4 years post-medical school residency	State medical boards Diplomate in Psychiatry achieved in exam offered by Board of Psychiatry and Neurology CEUs:
Pharmacist	Review client's medication therapy regimen; information resource for client and healthcare team; make recommendations for optimal pharmacologic outcome; supervise and inform about potential adverse effects.	5 year baccalaureate program. PhD	State licensure (RPh); some states use the national exam (NABPLEX). Board certification available in specialty areas, eg, oncology, nutrition, psychiatry CEUs:
Occupational Therapist (OT)	Utilize therapeutic goal-directed activities to evaluate, correct or prevent physical, mental or emotional dysfunction or to maximize functionality	BS or MS with a minimum of 6 months field work. OTA: Assistant who is associate degree prepared. OTA or OTA Certificate: min of 2 mos fieldwork	State exam to receive credential (OTR). COTA: certified OTA; exam given at least annually CEUs:
Physical; Therapist (PT)	Examination, evaluation, and utilization of exercises and rehabilitative procedures (eg, massage, hydrotherapy, electric stimulation) to achieve maximum functionality	Baccalaureate degree in physical therapy required for eligibility to take state exam. Masters degree	State exam for PT, licensed physical therapist and PTA, licensed PT assistant. Bi-annual license renewal: both categories CEUs: 3 hours every 2 years
Chaplain	Visits and spiritual ministry to staff, clients, family.	Masters degree in theology that includes at least 1 year of supervised clinical work. Most but not all chaplains are ordained ministers.	Certification: Chaplaincy Board of Certification; BCC credential normally not used. CEUs: 50 hours per year
Dietitian	Evaluate nutritional status; determine appropriate nutritional goals with client and family that recognizes cultural preferences	BS in food and nutrition in program that includes clinical experience. MS	RD: registered dietitian via national exam given by American Dietetic Assn. LD: licensed dietitian, in some states CEUs:

- Nursing issues and interventions
- Instruments/scales. See Professional Perceptions Quiz, p. 20-18.
- Meeting Observation Form, p. 20-19

4. Define the principles of successful teamwork and steps in the care-planning process.

A. The essential elements of teamwork are: coordination of services, shared responsibility, communication, and mutual accountability. Effective teams must work across settings and have an effective mechanism for information management and access. Patient assessment is usually shared with those providers who conduct a variety of geriatric assessment tests (see overlapping roles). With the team focus on the older person, providers must share information clearly and effectively. By focusing on the client, the team shares a common goal. Collaboration involves skills and hard work, and understanding the needs of team members for information and communication. (See communication.)

B. Teams usually meet to discuss patients. Effective meetings have structure and rules. Learning to be an effective team member requires practice and experience, such as learning to listen, organizing information, presenting effectively and efficiently.

Structure refers to the organization of the meeting. Ideally, the structure encourages efficient and effective

meetings. Elements essential to the structure of an effective meeting are:

1. Agenda (What do we expect to accomplish?)
2. Estimated timeline for completing agenda (Reasonable time frames).
3. Establishment of roles for the meeting. Members should expect to rotate the roles listed below but every meeting should have:
   - Leader or Facilitator (Calls meeting to order, has agenda, sets expectations) (See Facilitator, below).
   - Timekeeper (Keeps group on task).
   - Recorder (Keeps track of agreements about the care plan and modifications, and is responsible for recording changes to care plan).
4. Summary of agreements (Recorder reports agreements).
5. Evaluation/Reflection on team process (Both team process and outcome of the meeting are discussed).

Facilitator: This role is essential to avoid team dysfunction or difficulty. A facilitator role is one of neutrality; it keeps members on task. Facilitators clarify issues and model effective communication techniques. The facilitator elicits input from quiet or reluctant members and limits the dominance of boisterous members.

Team Rules: In addition to structure, teams must agree to a set of team behaviors. Rules set the expectations for behaviors within the meeting. Rules generally cover:

- Attendance and timeliness.
- Preparation of materials prior to meeting.
- How disruptions and interruptions (beepers, pagers) will be handled.
- Appropriate ways to manage conflict.
- Importance of contributing to, and fully participating in discussion.
- Acknowledgment of other professions' roles on teams.
- Sharing information in an atmosphere of respect and cooperation.
- Confidentiality of team discussion.
- Agreement that the team goal represents all participant's views.

C. Characteristics of effective teams:

- There is a known and agreed upon purpose, goals, and objectives.
- Roles and responsibilities are clear.
- Communication is open, sharing, and honest.
- There is disagreement without tyranny and constructive criticism without personal attack.
- Team members listen to each other.
- Team members are competent, professional, and personally effective, and make appropriate contributions.

- There is cooperation and coordination; decisions are reached by consensus.
- When decisions are made, assignments are clearly made, accepted, and carried out.
- Leadership shifts depending on the circumstances or issues.
- Team members support each other and act as different resources for the group.
- There is trust in each other, minimal struggles for power and the focus is on how best to get the job done.
- The team evaluates its own operations.

D. Steps in the care-planning process:

The purpose of a geriatric interdisciplinary team is to create a care plan that reflects the patient-specific goals, is feasible, and can be implemented in a cost-effective way. The team's goals should be clearly understood and agreed on by all members.

An interdisciplinary team that develops care plans and treatment goals must be able to incorporate all relevant information and know how different pieces of information relate. The ability of each discipline to add to the overall care plan depends on team member's understanding of the linkages between problems.

In concert with the questions listed below, use the grid on page 20-15 to assess the patient's situation from each need aspect (medical, emotional, etc.), identify the

impact of the problem on the patient's health and quality of life, identify what strengths or community or family resources could be redirected to address the problem and outcomes or triggers to notify the team that the plan is or is not working. In creating the plan of care, the plan should identify not only what activities are expected but also which member of the team—specifically—is responsible for initiation, follow-up, and reporting back to the team with the results.

Assess the actual functioning of the team—the team process as well as the efficiency of addressing clinical aspects or needs. Students should be able to develop the plan and set the priorities for the team plan of care (Steps 6 and 7 and Column 4) and be able to evaluate what to look for and when to determine if the plan was effective. The last step reinforces the team's responsibility for ongoing care management and joint accountability.

Considering the patient's medical, emotional, social, environmental, and economic needs, answer each of the following questions:

1. What is the overarching goal? At least three perspectives need to be considered and reconciled:
   - Patient
   - His or her family
   - Team

Content Outline

2. What are the patient's problems? (Again, consider them under a wide range of possible headings—medical, emotional, social, environmental, and economic.)
3. What is the impact of each problem on the patient's health and quality of life?
4. What strengths and resources does the patient have or can be mobilized to deal with each problem?
5. What additional information is needed to adequately define the problem or its implications?
6. What is the plan of care? (What needs to be done? Who will do it? When will it happen?)
7. What priority should be assigned to each problem (in either a linear order or categories of importance)? How important is its effect on the overarching problem? What other factors might influence its relative priority?
8. What outcomes should be expected for each problem? These should be expressed in measurable terms. When is the appropriate time to look for the outcomes?

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Content Outline

Overarching Team Goals:

Patient's: _____

Family's: _____

Team's: _____

Problem		Impact on Health and Quality of Life	Strengths/ Resources	Plan [What/ Who/When] (Includes Getting More Info)
	Expected Out-come	**(What to Look for, When)**	1.	
			2.	
			3.	
			4.	
			5.	
			6.	

Minnesota GITT Project, School of Public Health, University of Minnesota, Minneapolis, MN. Used by permission.

5. Discuss the concept of team conflict and conflict management skills.

A. Conflict on teams is inevitable. Team members need to be able to express opinions and disagree with each other. It is important to recognize that most people would rather avoid conflict but health teams encourage open discussion of differing views.
   - See Conflict Management Techniques.

B. The following communication skills are important to learn and practice on teams:
   - *Active listening:* Rephrase the issue and repeating the statement.
   - *Defining the problem:* Emphasize the areas of agreement and frame the area of disagreement.
   - *Open questions:* Ask questions that encourage discussion and permit disagreement. "Can you tell me more about it?" "What else do we need to consider?"
   - *Clarify responses:* Help others recognize member's attitudes and feelings.
   - *Paraphrase and reframe:* Summarize discussion to ensure that the disagreement is understood. Explore group problem solving and encourage solutions that have not been considered before.
   - See "Tips for Successful Consensus" in Instruments/ Scales section.

Content Outline

C. The following skills help make effective teams:
- Establish goals for patient/team.
- Recognize others' roles on team.
- Solicit relevant input from members.
- Recognize patient/family role on team.
- Respect family concerns.
- Negotiate team priorities.
- Establish tasks and person responsible.
- Ensure follow-up by reporting back.

D. Assess your ability to:
- Relate to team members as colleagues.
- Identify contribution to patient care from different disciplines.
- Apply your knowledge in a team setting.
- Develop an interdisciplinary plan of care.
- Raise appropriate issues; act as a patient advocate.
- Ensure patent/family preferences are considered.
- Handle disagreements.
- Strengthen cooperation among disciplines.
- Address issues succinctly.
- Recognize if the team is not functioning well.

Instruments/Scales

PROFESSIONAL PERCEPTIONS QUIZ

This tool may be adapted to a specific discipline.

Circle abbreviation indicating your discipline: MD GNP MSW PSY PA LTCA Other

Geriatric Care Skills	I Am Most Secure	I Am Least Secure	Other Discipline(s) Better Qualified or Similarly Qualified at Performing This Skill Than Mine
Eliciting and understanding patient's chief complaint or concern			
Performing a physical exam			
Educating patient about how to take medications			
Discussing advanced directives such as living wills and power of attorney for health care			
Educating patients about health insurance benefits and eligibility requirements			
Connecting patient with other community and social services (SI, housing agencies)			
Screening patient for sensory disorders			
Helping patients and families mediate decisions about living arrangements			
Assessing older patients for surgical risk			
Screening patients for drug misuse			
Arranging for appropriate home care equipment			
Assessing home safety			
Initiating discussions about hospice care			
Evaluating caregiver burden			
Prescribing medications			
Evaluating/Assessing mobility			
Referring to probate court, legal service			
Explaining laboratory test results to patient/family			

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Instruments/Scales

MEETING OBSERVATION FORM

Instructions: This form helps you see what kinds of contributions team members make during a discussion. Usually each member's contribution will cluster in a few categories. Data from this type of observation can help a team appreciate the different strengths members bring to the group. It can also help a team identify areas where they need to build skills to keep the team functioning well. Enter harsh marks or comments in the appropriate boxes when you see one of the behaviors listed.

	Team Member Names				
Behaviors					
Encourages others. Is friendly, warm, and responsive; uses eye contact and "uh-huhs" to support others' participation.					
Reduces tension. Reduces tension by using humor appropriately; gets the group to laugh; admits errors.					
Resolves disagreements. Works out disagreements; looks for ways to address objections and concerns; incorporates others' ideas into proposals.					
Notices group feelings. Senses and expresses team feelings and moods; is aware of significant shifts in tone and helps team be aware of shifts also.					
Suggests methods or procedures. Suggests ways of doing thing; steps to move the discussion forward; use of methods such as brainstorming, circling the group for opinions, multivoting, etc.					

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Instruments/Scales

TIPS FOR SUCCESSFUL TEAM CONSENSUS

1. **Listen carefully.** Ask for reasons and seek out assumptions behind statements. Be open to others' reactions to your ideas and consider them carefully.
2. **Encourage all members to participate fully.** Don't assume that silence means agreement. Periodically circle the group and have each member state his or her view.
3. **Seek out differences of opinion.** Probe for alternative viewpoints. Disagreements are natural and helpful because they increase the range of information and opinions that the group can use in its decision process.
4. **Search for alternatives that meet the goals of all members.** Don't assume someone must win and someone must lose. When there's a stalemate, look for the next most acceptable alternative for all members.
5. **Avoid changing your mind ONLY to avoid conflict.**
6. **Don't just argue for your point of view.** Seek ways of combining your ideas with others' views. Try to incorporate criticism of your ideas into your proposals.
7. **Balance power.** If one or two group members have more power or authority than the others (for example, if one member supervises the group), then the member with more authority should not state his/her view until late in the discussion after all other views have been heard.

8. **Make sure there is enough time.** The "reaching consent" part of consensus takes a lot of time. Meetings should be long enough to allow for full discussion, and there should be enough meetings for a discussion to emerge.
9. **Check understanding.** Check to see if everyone understands the decision and can explain why it was the best decision.

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Case Studies

CASE STUDY EXERCISE

Analyze the case of Debra J. and answer the questions by creating your proposed interdisciplinary care plan. Your group will function as a team and you will be evaluated by the observers on your ability to participate and plan a team meeting. The goal of the meeting is an interdisciplinary care plan for Ms. J. Please decide team roles and prepare an agenda for the meeting. Decide how you will conduct your team meeting. You should plan on 20 minutes for your team meeting.

Each group will have 10 minutes to present its final care plan to the entire group.

CASE 1: 55 years Old

Debra J. is a fifty-five year old woman, widowed and living in a small rural town in the Central Valley. She has worked on an assembly line at a local manufacturing plant for the past 25 years. She drives to work in an old car.

Debra married at 15, had her three children before age 20, and did not graduate from high school. Her husband died five years ago of a heart attack and left her a $70 dollar monthly pension from his work on the railroad. She lives on her family's farm with her 85-year-old mother. Her children are all away from home. Her two eldest live out-of-state and her youngest daughter lives in San Francisco.

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Case Studies

Medical History

BP 150/80 Weight 150 lbs. Height 5′5″

She has smoked 1 pack/day × 30 years; had her lower teeth extracted at age forty with dentures made, and had three normal vaginal deliveries. She has two or three urinary tract infections per year. In addition to her work on the assembly line, she works long hours on the family farm. She is beginning to show signs and symptoms of degenerative joint disease in her hands and knees. She comes to the clinic today for a simple check-up.

—What team members need to be involved in this case?

—What are Debra's most important health issues, and who should be involved in managing these issues?

—Develop a management plan for this patient.

Interdisciplinary Collaborative Teams in Primary Care: A Model Curriculum and Resource Guide. Pew Health Professions Commission California Primary Care Consortium, January 1995. Used by permission.

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Experiential/ Clinical Experiences

A. Use the case study to practice defining the patient's problems from different disciplines' perspectives. Practice running a team meeting with the role of leader, recorder, and timekeeper assigned. Report your group's discussion as an interdisciplinary care plan.

B. Ice Breaker/Team-building game. Sample.*

"Guess Who"

Purpose: Increase team member communication, facilitate support of members as individuals.

Supplies: One 3 × 5 card for each team member.

Give each member a 3 × 5 card on which to describe their favorite ice cream sundae and to write something that no one on the team knows about them and would be surprised to learn (or something that no one knows they've never done but want to do). Read each card aloud to the group and have the group decide who they think wrote the card. Give that card to the person chosen by the group. Each person can receive only one card. After everyone has a card, ask for those people who received the correct card to raise their hands. Everyone else needs to search out the correct owner of the card in their possession.

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*Cassell, C., Howe, J., and Leipzig, R. (Eds.). (2000). *Mount Sinai Geriatric Interdisciplinary Team Training Resource Manual.* New York: Mt. Sinai Hospital.

Experiential/ Clinical Experiences

C. Describe yourself in terms of an animal and explain what characteristics make you an effective team member.

D. Name game: This requires a ball.

Participants stand in a circle and learn the names of the people on the left and right. The ball is passed around and each player calls the name of the person to whom he or she passes the ball. Players then change position in the circle and throw the ball to the person who had been on their left or right. After a minute, the ball is thrown randomly and the player throwing the ball must call out the name the person who he or she throws it to.

E. Interview a person from a different discipline. Describe the education, practice skills, and licensure or credentialing for that discipline. Did any thing surprise you?

F. Write down on a piece of paper why you think students choose the following fields: medicine, nursing, and social work. Write down the reasons you chose to enter your profession. Compare the reasons you chose with the others. This should bring out preconceived stereotypes and open the discussion about expectations of disciplines.

G. Define the traditions in your discipline (modes of communication, dress code, titles, roles). Think about how those traditions have changed over time. Where are the historical conflicts and why?

Evaluation Strategies

1. Name two factors contributing to the increase in collaborative care practices.

   Answers: Recognition that the complex needs of elders draw on the skills from more than one profession.

   Growth in managed care that requires efficient coordination and nonduplication of services.

   Technology that allows complex care to be delivered in the community or nursing home and requires excellent communication among providers to be efficient and effective.

2. Match the description and the correct type of care:

   A. Multidisciplinary

   B. Uni-disciplinary

   C. Traditional care

   D. Interdisciplinary care

   Answers:

   A. A group of different people from the same discipline who work together.

   B. Physician-centered with initial and possibly only provider involved.

   C. A group of different providers from multiple disciplines who work collaboratively. They define a

common goal and share decision-making and responsibility for the patient's care.

D. A group of providers from different disciplines who independently create and implement their care plan.

3. Define three elements of structure that are important in meetings:

   Answers: Any of the following: agenda, timeline for completing agenda, role assignment (leader, timekeeper, recorder) summarizing agreements, evaluation/reflection on team process

4. Name three skills facilitators demonstrate in meetings:

   Answers: Neutrality; help clarify issues, keep members on task; encourage reluctant members to contribute and limit dominating members

5. Which of the following would promote effective team meetings? (Check all that apply)

   (a) Establishing regular meetings

   (b) Establishing ground rules on appropriate behaviors

   (c) Rotating leadership of the meeting

   (d) All of the above (answer)

Evaluation Strategies

6. List three communication techniques that can help manage conflict.

   Answer: Active listening, defining the problem, asking open-ended questions, clarifying responses, paraphrasing, and reframing.

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